

Airman MedXPress Exam Submittal Process For DIWS Exam (MID) Number: 200004752955

Page: 1

MedXPress

Applicant Name:	Andreas Guenter Lubitz
Applicant DOB:	12/18/1987
MedXPress Account Name:	andreaslubitz@aol.com
IP Address Used:	87.168.119.27
Exam Create Date:	06/14/2010
Exam Signed/Submitted On:	06/14/2010
Exam Confirmation Number:	38873566
Correct User Password was used by MedXPress applicant for submission:	Yes

AMCS

Import Date:	06/18/2010
Exam Imported for AME Name/Number:	JOERG SIEDENBURG / 3015
Exam Imported from MedXPress	JORG SIEDENBURG
Exam Date:	6/18/2010
Exam Submitted to FAA On:	06/18/2010
Exam Submitted for AME Name/Number:	JOERG SIEDENBURG / 3015
Exam Submitted to FAA by:	JORG SIEDENBURG
DIWS MID Number:	200004752955
Exam Modification(s) by AME:	See Modification Comments below.
AME certified that Exam Modifications were approved by applicant:	Yes

18M. In the mean-time there was a brief period of a reactive depression caused by a decompensation subsequent to excessive demands. The applicant was evaluated by [REDACTED] and found fit for JAR-FCL 3 Class 1 Medical fitness.;

Copy of FAA Form 8500-8 (Medical Certificate) or FAA Form 8420-2 (Medical Student Pilot Certificate) Issued													
GG-													
MEDICAL CERTIFICATE AND STUDENT PILOT CERTIFICATE													
This certifies that (Full name and address) ANDREAS Guenter LUBITZ [Redacted Address]													
Date of Birth	Height	Weight	Hair	Eyes	Sex								
12/18/1987			BLOND	BLUE	M								
has met the medical standards prescribed in part 67, Federal Aviation Regulations, for this class of Medical Certificate													
Limitations													
Date of Examination													
Examiner's Designation No.													
Signature													
Typed Name													
AIRMAN'S SIGNATURE													
1. Application For: <input type="checkbox"/> Airman Medical Certificate <input checked="" type="checkbox"/> Airman Medical and Student Pilot Certificate													
2. Class of Medical Certificate Applied For: <input type="checkbox"/> 1st <input type="checkbox"/> 2nd <input checked="" type="checkbox"/> 3rd													
3. Last Name LUBITZ			First Name ANDREAS										
Middle Name Guenter													
4. Social Security Number 888-07-0535													
5. Address Number / Street [Redacted]				Telephone Number [Redacted]									
City [Redacted]		State/Country [Redacted]		Zip Code [Redacted]									
6. Date of Birth 12/18/1987			7. Color of Hair BLOND		8. Color of Eyes BLUE								
Citizenship Germany					9. Sex Male								
10. Type of Airman Certificate(s) You Hold: <input checked="" type="checkbox"/> None <input type="checkbox"/> ATC Specialist <input type="checkbox"/> Flight Instructor <input type="checkbox"/> Recreational <input type="checkbox"/> Airline Transport <input type="checkbox"/> Flight Engineer <input type="checkbox"/> Private <input type="checkbox"/> Other <input type="checkbox"/> Commercial <input type="checkbox"/> Flight Navigator <input type="checkbox"/> Student													
11. Occupation Student Pilot			12. Employer Lufthansa Flight Training										
13. Has Your FAA Airman Medical Certificate Ever Been Denied, Suspended, or Revoked? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If yes, give date													
Total Pilot Time (Civilian Only)			16. Date of Last FAA Medical Application										
14. To Date 0		15. Past 6 months 0		04/09/2008 <input type="checkbox"/> No Prior Application									
17.a. Do You Currently Use Any Medication (Prescription or Nonprescription)? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (if yes, below list medication(s) used and check appropriate box). Previously Reported Yes No <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>													
17.b. Do You Ever Use Near Vision Contact Lens(es) While Flying? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No													
18. Medical History - HAVE YOU EVER IN YOUR LIFE BEEN DIAGNOSED WITH, HAD, OR DO YOU PRESENTLY HAVE ANY OF THE FOLLOWING? Answer "yes" or "no" for every condition listed below. In the EXPLANATIONS box below, you may note "PREVIOUSLY REPORTED, NO CHANGE" only if the explanation of the condition was reported on a previous application for an airman medical certificate and there has been no change in your condition. See Instructions Page													
Yes	No	Condition	Yes	No	Condition	Yes	No	Condition	Yes	No	Condition		
a. <input type="checkbox"/>	<input checked="" type="checkbox"/>	Frequent or severe headaches	g. <input type="checkbox"/>	<input checked="" type="checkbox"/>	Heart or vascular trouble	m. <input type="checkbox"/>	<input checked="" type="checkbox"/>	Mental disorders of any sort; depression, anxiety, etc.	r. <input type="checkbox"/>	<input checked="" type="checkbox"/>	Military medical discharge		
b. <input type="checkbox"/>	<input checked="" type="checkbox"/>	Dizziness or fainting spell	h. <input type="checkbox"/>	<input checked="" type="checkbox"/>	High or low blood pressure	n. <input type="checkbox"/>	<input checked="" type="checkbox"/>	Substance dependence or failed a drug test ever; or substance abuse or use of illegal substance in the last 2 years.	s. <input type="checkbox"/>	<input checked="" type="checkbox"/>	Medical rejection by military service		
c. <input type="checkbox"/>	<input checked="" type="checkbox"/>	Unconsciousness for any reason	i. <input type="checkbox"/>	<input checked="" type="checkbox"/>	Stomach, liver, or intestinal trouble	o. <input type="checkbox"/>	<input checked="" type="checkbox"/>	Alcohol dependence or abuse	t. <input type="checkbox"/>	<input checked="" type="checkbox"/>	Rejection for life or health insurance		
d. <input type="checkbox"/>	<input checked="" type="checkbox"/>	Eye or vision trouble except glasses	j. <input type="checkbox"/>	<input checked="" type="checkbox"/>	Kidney stone or blood in urine	p. <input type="checkbox"/>	<input checked="" type="checkbox"/>	Suicide attempt	u. <input type="checkbox"/>	<input checked="" type="checkbox"/>	Admission to hospital		
e. <input type="checkbox"/>	<input checked="" type="checkbox"/>	Hay fever or allergy	k. <input type="checkbox"/>	<input checked="" type="checkbox"/>	Diabetes	q. <input type="checkbox"/>	<input checked="" type="checkbox"/>	Motion sickness requiring medication	x. <input type="checkbox"/>	<input checked="" type="checkbox"/>	Other illness, disability, or surgery		
f. <input type="checkbox"/>	<input checked="" type="checkbox"/>	Asthma or lung disease	l. <input type="checkbox"/>	<input checked="" type="checkbox"/>	Neurological disorders; epilepsy, seizures, stroke, paralysis, etc.				y. <input type="checkbox"/>	<input checked="" type="checkbox"/>	Medical disability benefits		
Arrest, Conviction, and/or Administrative Action History - See Instructions Page													
Yes	No	History of (1) any arrest(s) and/or conviction(s) involving driving while intoxicated by, while impaired by, or while under the influence of alcohol or a drug; or (2) history of any arrest(s), and/or conviction(s), and/or administrative action(s) involving an offense(s) which resulted in the denial, suspension, cancellation, or revocation of driving privileges or which resulted in attendance at an educational or a rehabilitation program.								Yes	No	History of nontraffic conviction(s) (misdemeanors or felonies).	
v. <input type="checkbox"/>	<input checked="" type="checkbox"/>									w. <input type="checkbox"/>	<input checked="" type="checkbox"/>		
Explanations: See Instructions Page										FOR FAA USE Review Action Codes			
19. Visits to Health Professional Within Last 3 Years. <input type="checkbox"/> Yes (Explain Below) <input checked="" type="checkbox"/> No See Instructions Page													
Date	Name, Address, and Type of Health Professional Consulted								Reason				
- NOTICE - Whoever in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme, or device a material fact, or who makes any false, fictitious or fraudulent statements or representations, or omits any material fact, or who makes any false, fictitious or fraudulent statements or representations, or omits any material fact, may be fined up to \$250,000 or imprisoned not more than 5 years, or both. (18 U.S. Code Secs. 1001; 3571).													
20. Applicant's National Driver Register and Certifying Declarations I hereby authorize the National Driver Register (NDR), through a designated State Department of Motor Vehicles, to furnish to the FAA information pertaining to my driving record. This consent constitutes authorization for a single access to the information contained in the NDR to verify information provided in this application. Upon my request the FAA shall make the information received from the NDR, if any, available for my review and written comment. Authority: 23 U.S. Code 401, Note. NOTE: ALL persons using this form must sign it. NDR consent, however, does not apply unless this form is used as an application for Medical Certificate or Medical Certificate and Student Pilot Certificate. I hereby certify that all statements and answers provided by me on this application form are complete and true to the best of my knowledge, and I agree that they are to be considered part of the basis for issuance of any FAA certificate to me. I have also read and understand the Privacy Act statement that accompanies this form.													
Electronically signed by : andreaslubitz@aol.com / Password Verified										Date 06/14/2010			

Form 8500-8 Continuation Sheet

17.a. Medications (From page 1):
Medication

Previously Reported
Yes No

18. Explanations (From page 1):

19. Visits to Health Professional Within Last 3 Years. (From page 1):

NOTE: FAA/Original Copy of the Report of Medical Examination Must be TYPED.

REPORT OF MEDICAL EXAMINATION															
21. Height (inches) 68		22. Weight (pounds) 150		23. Statement of Demonstrated Ability (SODA) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Defect Noted:					24. SODA Serial Number						
CHECK EACH ITEM IN APPROPRIATE COLUMN				Normal	Abnormal	CHECK EACH ITEM IN APPROPRIATE COLUMN				Normal	Abnormal				
25. Head, face, neck, and scalp				X		37. Vascular system (Pulse, amplitude and character, arms, legs, others)				X					
26. Nose				X		38. Abdomen and viscera (including hernia)				X					
27. Sinuses				X		39. Anus (Not including digital examination)				X					
28. Mouth and throat				X		40. Skin				X					
29. Ears, general (Internal and external canals; Hearing under item 49)				X		41. G-U system (Not including pelvic examination)				X					
30. Ear Drums (Perforation)				X		42. Upper and lower extremities (Strength and range of motion)				X					
31. Eyes, general (Vision under items 50 to 54)				X		43. Spine, other musculoskeletal				X					
32. Ophthalmoscopic				X		44. Identifying body marks, scars, tattoos (Size & location)				X					
33. Pupils (Equality and reaction)				X		45. Lymphatics				X					
34. Ocular motility (Associated parallel movement, nystagmus)				X		46. Neurologic (Tendon reflexes, equilibrium, senses, cranial nerves, coord., etc.)				X					
35. Lungs and chest (Not including breast examination)				X		47. Psychiatric (Appearance, behavior, mood, communication, and memory)				X					
36. Heart (Precordial activity, rhythm, sounds, and murmurs)				X		48. General systemic				X					
NOTES: Describe every abnormality in detail. Enter applicable item number before each comment. Use additional sheets if necessary and attach to this form. none															
49. Hearing		Record Audiometric Speech Discrimination Score Below		Right Ear					Left Ear						
Conversational Voice Test at 6 Feet				Audiometer Threshold in decibels		500	1000	2000	3000	4000	500	1000	2000	3000	4000
<input checked="" type="checkbox"/> Pass <input type="checkbox"/> Fail															
50. Distant Vision				51.a. Near Vision				51.b. Intermediate Vision -- 32 inches				52. Color Vision			
Right 20/ 20		Corrected to 20/		Right 20/ 20		Corrected to 20/		Right 20/ 20		Corrected to 20/		<input checked="" type="checkbox"/> Pass			
Left 20/ 20		Corrected to 20/		Left 20/ 20		Corrected to 20/		Left 20/ 20		Corrected to 20/		<input type="checkbox"/> Fail			
Both 20/ 20		Corrected to 20/		Both 20/ 20		Corrected to 20/		Both 20/ 20		Corrected to 20/					
53. Field of Vision		54. Heterophoria 20' (in prism diopters)				Esophoria		Exophoria		Right Hyperphoria		Left Hyperphoria			
<input checked="" type="checkbox"/> Normal <input type="checkbox"/> Abnormal						0		0		0		0			
55. Blood Pressure		56. Pulse (Resting)		57. Urine Test (if abnormal, give results)				Albumin		Sugar		58. ECG (Date)			
(Sitting, mm of Mercury)		Systolic Diastolic		<input checked="" type="checkbox"/> Normal <input type="checkbox"/> Abnormal				Normal		Normal		M M D D Y Y Y Y			
130 / 90		64													
59. Other Tests Given															
60. Comments on History and Findings: AME shall comment on all "YES" answers in the Medical History section and for abnormal findings of the examination. (Attach all consultation reports, ECGs, X-rays, etc. to this report before mailing.) 18M: In the mean-time there was a brief period of a reactive depression caused by a decompensation subsequent to excessive demands . The applicant was evaluated by [redacted] and found fit for JAR-FCL 3 Class 1 Medical fitness. Applicant is continuing as a flight student without any further abnormalities and was found fit for JAR-FCL Class medical fitness. Page 1 has been modified: 18M>>18m changed from N to Y Modification comments from AME:18M.In the mean-time there was a brief period of a reactive depression caused by a decompensation subsequent to excessive demands . The applicant was evaluated by [redacted] and found fit for JAR-FCL 3 Class 1 Medical fitness.												FOR FAA USE Pathology Codes: Coded By: Clinical Reject			
Significant Medical History <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO Abnormal Physical Findings <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO															
61. Applicant's Name ANDREAS Guentler LUBITZ															
62. Has Been Issued -- <input type="checkbox"/> Medical Certificate <input type="checkbox"/> Medical & Student Pilot Certificate <input checked="" type="checkbox"/> No Certificate Issued -- Deferred for Further Evaluation <input type="checkbox"/> FAA ATC-Deferred -- No Certificate Issued <input type="checkbox"/> Has Been Denied -- Letter of Denial Issued (Copy Attached)															
63. Disqualifying Defects (List by item number)															
64. Medical Examiner's Declaration -- I hereby certify that I have personally reviewed the medical history and personally examined the applicant named on this medical examination report. This report with any attachment embodies my findings completely and correctly.															
Date of Examination				Aviation Medical Examiner's Name				Aviation Medical Examiner's Signature							
M M D D Y Y Y Y				JOERG SIEDENBURG											
06/18/2010				Street Address				AME Serial Number 03015							
				WEG BEIM JAGER 193, GEB 126											
				City HAMBURG State Zip Code 22313				AME Telephone 696-964-7624							

Form 8500-8 Continuation Sheet

Applicant Name : ANDREAS Guenter LUBITZ

Applicant MID : 200004752955

17.a. Medications (From page 1):

Medication

Previously Reported

Yes No

18. Explanations (From page 1):

19. Visits to Health Professional Within Last 3 Years. (From page 1):

Notes (From page 2):

none

Other Tests Given (From page 2):

Comments on History and Findings (From page 2):

18m: In the mean-time there was a brief period of a reactive depression caused by a decompensation subsequent to excessive demands. The applicant was evaluated by [REDACTED] and found fit for JAR-FCL 3 Class 1 Medical fitness. Applicant is continuing as a flight student without any further abnormalities and was found fit for JAR-FCL Class medical fitness. Page 1 has been modified: 18M>>18m changed from N to Y|| Modification comments from AME:18M. In the mean-time there was a brief period of a reactive depression caused by a decompensation subsequent to excessive demands. The applicant was evaluated by [REDACTED] and found fit for JAR-FCL 3 Class 1 Medical fitness.;

AME Actions:

Applicant Previously Assessed

☐ 1. Has OSA diagnosis and is on Special Issuance. Reports to follow.

☐ 2. Has OSA diagnosis and is currently being treated OR has had previous OSA assessment. NOT on Special Issuance. Reports to follow.

Applicant Not at Risk

☐ 3. Determined to NOT be at risk for OSA at this examination.


Applicant at Risk/Severity to be Assessed

☐ 4. Discuss OSA risk with airman and provide educational materials.

☐ 5. At risk for OSA. AASM sleep apnea assessment required. Reports to follow.

Applicant Risk/Severity high

☐ 6. Deferred. Immediate safety risk. AASM sleep apnea assessment required. Reports to follow.

UNITED STATES OF AMERICA Department of Transportation Federal Aviation Administration		GX-0260689	
MEDICAL CERTIFICATE THIRD CLASS AND STUDENT PILOT CERTIFICATE			
This certifies that (Full name and address): ANDREAS Guenter LUBITZ [REDACTED] Germany			
Date of Birth	Height	Weight	Hair
12/18/1987	68	150	BLOND
Eyes	Sex		
BLUE	M		
has met the medical standards prescribed in part 67, Federal Aviation Regulations, for this class of Medical Certificate.			
<div style="text-align: center;">  </div>			
Date of Examination 06/18/2010		Examiner's Designation No. 00029	
Examiner	Signature <i>Warren S. Silberman, DO, MPH</i> Typed Name WARREN S. SILBERMAN, DO		
AIRMAN'S SIGNATURE			
Applicant ID: 2001587238		Control No.: 200004752955	

FAA Form 8420-2 (9-08) Supersedes Previous Edition

NSN: 0052-00-670-7002

(Cut on dashed line)



AEROSPACE MEDICAL CERTIFICATION DIVISION, AAM - 300
FAA Civil Aerospace Medical Institute
Mike Monroney Aeronautical Center
P.O. Box 26080
Oklahoma City, OK 73125-9914

ANDREAS Guenter LUBITZ

[REDACTED]
[REDACTED] Germany

Dear Airman:

Above is your new medical certificate. It supersedes any previous one you may have been issued.

To validate this certificate, it is necessary that you sign it in the space provided (Airman's Signature).

This certificate must be in your possession at all times while exercising your pilot privileges.

Passenger-Carrying Prohibited STUDENT PILOT CERTIFICATE			
<p>CONDITIONS OF ISSUE: This certificate shall be in the personal possession of the airman at all times while exercising the privileges of his or her airman certificate. The issuance of a medical certificate by an Aviation Medical Examiner may be reversed by the FAA within 60 days. Section 61.19 of Title 14 of the Code of Federal Regulations (14 CFR part 61) sets forth the duration of a student pilot certificate. Unless otherwise limited, the duration of a medical certificate is set forth in 61.23. The holder of this certificate is governed by the provisions of 61.53 relating to medical deficiency (14 CFR part 61).</p>			
<p>CERTIFIED INSTRUCTOR'S ENDORSEMENT FOR STUDENT PILOTS</p> <p>I certify that the holder of this certificate has met the requirements of the regulations and is competent for the following:</p>			
Date	Make and Model of Aircraft	Instructor's Signature	Instructor's Cert. No.
			Exp. Date
A. To Solo The Following Aircraft		B. To Make Solo Flights	
cross-country		cross-country	
Aircraft Category		Aircraft Category	
Airplane		Airplane	
Glider		Glider	
Rotorcraft		Rotorcraft	



U.S. Department
of Transportation
**Federal Aviation
Administration**

Mike Monroney Aeronautical Center
Civil Aerospace Medical Institute (CAMI)
Aerospace Medical Certification Division

P.O. Box 26080
Oklahoma City, OK 73125-9914

July 08, 2010

ANDREAS GUENTER LUBITZ

[REDACTED]
GERMANY

Ref: PI# 2169319
App ID# 2001587238

Dear Mr. Lubitz:

Your report of physical examination has been received. Based upon our review of the information submitted, we are unable to establish your eligibility to hold an airman medical certificate at this time.

Due to your history of reactive depression, please submit a current detailed status report from your prescribing physician. The report should include the date medication(s) were discontinued and confirmation of no recurrence of symptoms since discontinuing medication(s). The report should also include diagnosis, prognosis without medication(s), follow-up plan, and copies of treatment records.

Upon review of the aforementioned information, additional data may be required.

Following our review of the requested data, we will notify you regarding your eligibility for medical certification. We will appreciate your use of the above reference numbers on any correspondence.

Please note that your medical certification has not been denied at this time; however, if no reply is received within 30 days from the date of this letter, we will have no alternative except to deny your application in accordance with Title 14 of the Code of Federal Regulations (CFRs), Section 67.413.

Sincerely,

Sandy Claymer for

Warren S. Silberman, D.O., M.P.H.
Manager, Aerospace Medical Certification Division
~~Civil Aerospace Medical Institute~~

cc: Joerg Siedenburg M.D.

skc/tdz



U.S. Department
of Transportation
**Federal Aviation
Administration**

Mike Monroney Aeronautical Center
Civil Aerospace Medical Institute (CAMI)
Aerospace Medical Certification Division

P.O. Box 26080
Oklahoma City, OK 73125-9914

July 28, 2010

ANDREAS GUENTER LUBITZ

[REDACTED]

GERMANY

Ref: PI# 2169319
App ID# 2001587238

Dear Mr. Lubitz:

Our review of your medical records has established that you are eligible for a third-class medical certificate.

Enclosed is your medical certificate. It requires your signature.

You are cautioned to abide by Title 14 of the Code of Federal Regulations (CFRs), Section 61.53, relating to physical deficiency. Because of your history of reactive depression, operation of aircraft is prohibited at any time new symptoms or adverse changes occur or any time medication and/or treatment is required.

Use of the above reference numbers on future correspondence and/or reports will aid us in locating your file.

Sincerely,

Sandy Clayman for

Warren S. Silberman, D.O., M.P.H.
Manager, Aerospace Medical Certification Division
Civil Aerospace Medical Institute

Enclosure

cc: Joerg Siedenburg M.D.

skc

U.S. Department
of Transportation
Federal Aviation
Administration
WAKE MCKINNEY AERONAUTICAL CENTER
PO BOX 25882
OKLAHOMA CITY OK 73125

Official Business
AC Form 1350-47 (9-81) (NPN 0952-09-577-9000)

4AM-300

Return
AIRMAIL

RÜCKSENDEVERMERKE

- ☒ Bei Lufthansa unbekannt
- ☐ Bei Lufthansa ausgeschlossen
- ☐ Mitarbeiter ins Ausland versetzt
- ☒ Ohne Angabe der Organisations-Einheit bei Lufthansa nicht zustellbar
- ☐ Organisations-Einheit unbekannt
- ☐ Privatpost bitte an Privatanschrift
- Lufthansa, FRA KRM-BP

Empfänger nicht zu ermitteln
ZURÜCK
Nachricht übergeben durch Deutsche Post/E

AIR MAIL

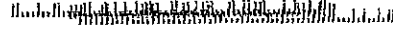


UNITED STATES POSTAGE
02 24 \$ 00.98⁰
000-4236911 JUL 09 2010
MAILER FROM ZIP CODE 73125

OFFICE OF
ROSPACE MEDICINE
OKLAHOMA CITY, OK

AIRMAIL

73125-25882





U.S. Department
of Transportation
Federal Aviation
Administration

Mike Monroney Aeronautical Center
Civil Aerospace Medical Institute (CAMI)
Aerospace Medical Certification Division

P.O. Box 26080
Oklahoma City, OK 73125-9914

July 08, 2010

ANDREAS GUENTER LUBITZ

[REDACTED]

GERMANY

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Sincerely,

Sandy Clayman for

Warren S. Silberman, D.O., M.P.H.
Manager, Aerospace Medical Certification Division
Civil Aerospace Medical Institute

cc: Joerg Siedenburg M.D.

sko/tdz

JOERG SIEDENBURG M.D.
AIRPORTRING TOR 21
FRANKFURT 60546
GERMANY

11100
Tel: 0321 7133 77
Telefax: 0321 7133 50 05
Fachübersetzungen

Certified translation from German

Medical specialist for psychiatry and psychotherapy

Phone: [REDACTED]

Fax: [REDACTED]

Clinic

[REDACTED] on 10th July, 2009

Andreas Lubitz, born on 18th December, 1987, [REDACTED]

Dear Colleague,

Anamnesis:

A considerable remission has been obtained by medication with Cipralex and Mirtazapin, as well as by a psychotherapeutic treatment. Finally, the medication has been tapered.

Psychopathologic findings:

Patient alert and mentally fully oriented, with no retentivity or memory disorders; formal train of thoughts without pathologic findings; no phobias and compulsions; no delusion; no alusia or depersonalisation; emotionally stable; oscillatory; capable of exercise; no sleep disorders.

Diagnosis:

(ICD:F32.2G) Severe depressive episode without psychotic symptoms in complete remission

Epicrisis and therapy:

In the case of Mr. Lubitz, modified living conditions caused the onset of a depressive episode. By a drug therapy and a psychotherapeutic treatment, which enabled him to develop the sufficient resources for getting on with similar situations in the future, the complete remission was obtained. The medication could be stopped.

Mr. Lubitz completely recovered, there is not any residuum remained. The treatment has been finished.

Best regards

This report is computer-generated, hence it is valid without signature.
On demand, we shall gladly send you a copy with signature.

804 A - 3 - 000 0002
OFFICE OF
AEROSPACE MEDICINE
OKLAHOMA CITY, OK

*The correctness and completeness of the above
translation from German is hereby certified.*

Grosshansdorf, 21.7.10

Peter Strauß



*Translator for English, officially authorised for the
courts and public prosecution authorities of the Federal
State Schleswig-Holstein.*



Hilfslup
28485 Bremen
Tel. (0421) 783977
Telefax (0421) 165 58 05
Fachberatungen

Certified translation from German

Dipl.-Psych. [REDACTED]

Psychological psychotherapist
Psychotherapist for children and juveniles

Mr.
Andreas Lubitz

[REDACTED]
[REDACTED]
Phone: [REDACTED]
Fax: [REDACTED]

23rd February, 2010

Psychological Psychotherapeutic Certificate

Mr. Andreas Lubitz, born on 18th December, 1987, resident in [REDACTED]
[REDACTED], was under my psychotherapeutic treatment from January to October 2009. Mr.
Lubitz' high motivation and active participation contributed to the successful completion of
the treatment, after the management of symptoms.

Dipl.-Psych. [REDACTED]
Psychological psychotherapist
Psychotherapist for children and juveniles

Signature

Medical specialist for psychiatry and psychotherapy

Fax: [REDACTED]

Clinic

on 10th July, 2009

Andreas Lubitz, born on 18th December, 1987,

. Dear Colleague,

Anamnesis:

A considerable remission has been obtained by medication with Ciprexal and Mirtazapin, as well as by a psychotherapeutic treatment. Finally, the medication has been tapered.

Psychopathologic findings:

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In the case of Mr. Lubitz, modified living conditions caused the onset of a depressive episode. By a drug therapy and a psychotherapeutic treatment, which enabled him to develop the sufficient resources for getting on with similar situations in the future, the complete remission was obtained. The medication could be stopped.

Mr. Lubitz completely recovered, there is not any residuum remained. The treatment has been finished.

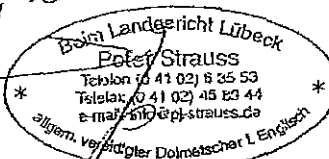
Best regards

This report is computer-generated, hence it is valid without signature.
On demand, we shall gladly send you a copy with signature.

*The correctness and completeness of the above
translation from German is hereby certified.*

Grosshansdorf, 21.7.10

Peter Strauß



*Translator for English, officially authorised for the
courts and public prosecution authorities of the Federal
State Schleswig-Holstein.*



Certified translation from German

Dipl.-Psych. [REDACTED]

Psychological psychotherapist
Psychotherapist for children and juveniles

Mr. [REDACTED]
[REDACTED]
[REDACTED]

[REDACTED]
Phone: [REDACTED]
Fax: [REDACTED]

23rd February, 2010

Psychological Psychotherapeutic Certificate

Mr. Andreas Lubitz, born on 18th December, 1987, resident in [REDACTED]
[REDACTED], was under my psychotherapeutic treatment from January to October 2009. Mr.
Lubitz' high motivation and active participation contributed to the successful completion of
the treatment, after the management of symptoms.

Dipl.-Psych. [REDACTED]

Psychological psychotherapist
Psychotherapist for children and juveniles

Signature

Airman MedXPress Exam Submittal Process For DIWS Exam (MID) Number: 200003801199

Page: 1

MedXPress

Applicant Name:	Andreas Guenter Lubitz
Applicant DOB:	12/18/1987
MedXPress Account Name:	andreaslubitz@aol.com
IP Address Used:	87.168.119.27
Exam Create Date:	04/04/2008
Exam Signed/Submitted On:	04/04/2008
Exam Confirmation Number:	71413544841
Correct User Password was used by MedXPress applicant for submission:	No

AMCS

Import Date:	04/09/2008
Exam Imported for AME Name/Number:	MATTHIAS J A VON MUELMANN / 15851
Exam Imported from MedXPress	MATTHIAS J A VON MUELMANN
by: Exam Date:	4/9/2003
Exam Submitted to FAA On:	04/09/2008
Exam Submitted for AME Name/Number:	MATTHIAS J A VON MUELMANN / 15851
Exam Submitted to FAA by:	MATTHIAS J A VON MUELMANN
DIWS MID Number:	200003801199
Exam Modification(s) by AME:	none
AME certified that Exam Modifications were approved by applicant:	N/A

Form Approved OMB NO. 2120-0034

NSN: 0052-00-670-6002

Form 8500-8 Continuation Sheet

17.a. Medications (From page 1):
Medication

Previously Reported
Yes No

18. Explanations (From page 1):

19. Visits to Health Professional Within Last 3 Years. (From page 1);

Applicant Must Complete ALL 20 Items (Except For Shaded Areas) PLEASE PRINT

Form Approved OMB NO. 2120-0034

Copy of FAA Form 8500-8
(Medical Certificate) or FAA
Form 8420-2 (Medical Student
Pilot Certificate) (Issued)

FF-6866174

**MEDICAL CERTIFICATE THIRD CLASS
AND STUDENT PILOT CERTIFICATE**

This certifies that (Full name and address):
ANDREAS Guenther LUBITZ
[Redacted Address]

Date of Birth	Height	Weight	Hair	Eyes	Sex
12/18/1987	6'7"	152	BLOND	BLUE	M

has met the medical standards prescribed in part 67, Federal Aviation Regulations, for this class of Medical Certificate

Limitations: [None]

Date of Examination: 04/09/2008
Examiner's Designation No: 15851

Signature: [Redacted]
Typed Name: MATTHIAS A VON MUELMANN

AIRMAN'S SIGNATURE

1. Application For:
☐ Airman Medical Certificate ☒ Airman Medical and Student Pilot Certificate

2. Class of Medical Certificate Applied For:
☐ 1st ☐ 2nd ☒ 3rd

3. Last Name: LUBITZ
First Name: ANDREAS
Middle Name: Guenther

4. Social Security Number: 888-07-0535

5. Address Number / Street: [Redacted]
City: [Redacted] State/Country: [Redacted] Zip Code: [Redacted]

6. Date of Birth: 12/18/1987
Citizenship: Germany

7. Color of Hair: BLOND
8. Color of Eyes: BLUE
9. Sex: Male

10. Type of Airman Certificate(s) You Hold:
☐ None ☐ ATC Specialist ☐ Flight Instructor ☐ Recreational
☐ Airline Transport ☐ Flight Engineer ☒ Private ☐ Other
☐ Commercial ☐ Flight Navigator ☐ Student

11. Occupation: Student Pilot
12. Employer: Deutsche Lufthansa AG

13. Has Your FAA Airman Medical Certificate Ever Been Denied, Suspended, or Revoked?
☐ Yes ☒ No If yes, give date

Total Pilot Time (Civilian Only)
14. To Date: 0
15. Past 6 months: 0

16. Date of Last FAA Medical Application: [Redacted] ☒ No Prior Application

17.a. Do You Currently Use Any Medication (Prescription or Nonprescription)?
☒ No ☐ Yes (If yes, below list medication(s) used and check appropriate box).

Previously Reported	
Yes	No
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

17.b. Do You Ever Use Near Vision Contact Lens(es) While Flying? ☐ Yes ☒ No

18. Medical History - HAVE YOU EVER IN YOUR LIFE BEEN DIAGNOSED WITH, HAD, OR DO YOU PRESENTLY HAVE ANY OF THE FOLLOWING? Answer "yes" or "no" for every condition listed below. In the EXPLANATIONS box below, you may note "PREVIOUSLY REPORTED, NO CHANGE" only if the explanation of the condition was reported on a previous application for an airman medical certificate and there has been no change in your condition. See Instructions Page

Yes	No	Condition	Yes	No	Condition	Yes	No	Condition
<input type="checkbox"/>	<input checked="" type="checkbox"/>	Frequent or severe headaches	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Heart or vascular trouble	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Mental disorders of any sort; depression, anxiety, etc.
<input type="checkbox"/>	<input checked="" type="checkbox"/>	Dizziness or fainting spell	<input type="checkbox"/>	<input checked="" type="checkbox"/>	High or low blood pressure	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Substance dependence or failed a drug test ever; or substance abuse or use of illegal substance in the last 2 years.
<input type="checkbox"/>	<input checked="" type="checkbox"/>	Unconsciousness for any reason	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Stomach, liver, or intestinal trouble	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Alcohol dependence or abuse
<input type="checkbox"/>	<input checked="" type="checkbox"/>	Eye or vision trouble except glasses	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Kidney stone or blood in urine	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Suicide attempt
<input type="checkbox"/>	<input checked="" type="checkbox"/>	Hay fever or allergy	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Motion sickness requiring medication
<input type="checkbox"/>	<input checked="" type="checkbox"/>	Asthma or lung disease	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Neurological disorders; epilepsy, seizures, stroke, paralysis, etc.			

Conviction and/or Administrative Action History -- See Instructions Page

Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>	History of (1) any conviction(s) involving driving while intoxicated by, while impaired by, or while under the influence of alcohol or a drug; or (2) history of any conviction(s) or administrative action(s) involving an offense(s) which resulted in the denial, suspension, cancellation, or revocation of driving privileges or which resulted in attendance at an educational or a rehabilitation program.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>	History of nontraffic conviction(s) (misdemeanors or felonies).
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Explanations: See Instructions Page
None

FOR FAA USE
Review Action Codes

19. Visits to Health Professional Within Last 3 Years. ☐ Yes (Explain Below) ☒ No See Instructions Page

Date	Name, Address, and Type of Health Professional Consulted	Reason

- NOTICE -
Whoever in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme, or device a material fact, or who makes any false, fictitious or fraudulent statements or representations, or enters, may be fined up to \$250,000 or imprisoned not more than 5 years, or both. (18 U.S. Code Secs. 1001; 3571).

20. Applicant's National Driver Register and Certifying Declarations
I hereby authorize the National Driver Register (NDR), through a designated State Department of Motor Vehicles, to furnish to the FAA information pertaining to my driving record. This consent constitutes authorization for a single access to the information contained in the NDR to verify information provided in this application. Upon my request, the FAA shall make the information received from the NDR, if any, available for my review and written comment. Authority: 23 U.S. Code 401, Note.

NOTE: ALL persons using this form must sign it. NDR consent, however, does not apply unless this form is used as an application for Medical Certificate or Medical Certificate and Student Pilot Certificate.

I hereby certify that all statements and answers provided by me on this application form are complete and true to the best of my knowledge, and I agree that they are to be considered part of the basis for issuance of any FAA certificate to me. I have also read and understand the Privacy Act statement that accompanies this form.

Signature of Applicant: [Redacted] Date: 04/04/2008

NOTE: FAA/Original Copy of the Report of Medical Examination Must be TYPED.

REPORT OF MEDICAL EXAMINATION															
21. Height (inches) 67		22. Weight (pounds) 152		23. Statement of Demonstrated Ability (SODA) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Defect Noted: None						24. SODA Serial Number					
CHECK EACH ITEM IN APPROPRIATE COLUMN				Normal	Abnormal	CHECK EACH ITEM IN APPROPRIATE COLUMN				Normal	Abnormal				
25. Head, face, neck, and scalp				X		37. Vascular system (Pulse, amplitude and character; arms, legs, others)				X					
26. Nose				X		38. Abdomen and viscera (including hernia)				X					
27. Sinuses				X		39. Anus (Not including digital examination)				X					
28. Mouth and throat					X	40. Skin				X					
29. Ears, general (Internal and external canals; Hearing under item 49)				X		41. G-U system (Not including pelvic examination)				X					
30. Ear Drums (Perforation)				X		42. Upper and lower extremities (Strength and range of motion)				X					
31. Eyes, general (Vision under items 50 to 54)				X		43. Spine, other musculoskeletal				X					
32. Ophthalmoscopic				X		44. Identifying body marks, scars, tattoos (Size & location)				X					
33. Pupils (Equality and reaction)				X		45. Lymphatics				X					
34. Ocular motility (Associated parallel movement, nystagmus)				X		46. Neurologic (Tendon reflexes, equilibrium, senses, cranial nerves, coord., etc.)				X					
35. Lungs and chest (Not including breast examination)				X		47. Psychiatric (Appearance, behavior, mood, communication, and memory)				X					
36. Heart (Precordial activity, rhythm, sounds, and murmurs)				X		48. General systemic				X					
NOTES: Describe every abnormality in detail. Enter applicable item number before each comment. Use additional sheets if necessary and attach to this form. 28: Tonsillectomy															
49. Hearing		Record Audiometric Speech Discrimination Score Below		Audiometer Threshold in decibels		Right Ear					Left Ear				
Conversational Voice Test at 6 Feet						500	1000	2000	3000	4000	500	1000	2000	3000	4000
<input checked="" type="checkbox"/> Pass <input type="checkbox"/> Fail						10	10	10	10	10	10	10	10	10	10
50. Distant Vision				51.a. Near Vision				51.b. Intermediate Vision -- 32 Inches				52. Color Vision			
Right 20/ 20		Corrected to 20/		Right 20/ 20		Corrected to 20/		Right 20/ 20		Corrected to 20/		<input checked="" type="checkbox"/> Pass			
Left 20/ 20		Corrected to 20/		Left 20/ 20		Corrected to 20/		Left 20/ 20		Corrected to 20/		<input type="checkbox"/> Fail			
Both 20/ 20		Corrected to 20/		Both 20/ 20		Corrected to 20/		Both 20/ 20		Corrected to 20/					
53. Field of Vision		54. Heterophoria 20' (in prism diopters)		Esophoria		Exophoria		Right Hyperphoria		Left Hyperphoria					
<input checked="" type="checkbox"/> Normal <input type="checkbox"/> Abnormal				0		1		0		0					
55. Blood Pressure		56. Pulse (Resting)		57. Urine Test (If abnormal, give results)				Albumin		Sugar		58. ECG (Date)			
(Sitting, mm of Mercury)		Systolic Diastolic		<input checked="" type="checkbox"/> Normal <input type="checkbox"/> Abnormal								MM DD YYYY			
		120 / 80										04/09/2008			
59. Other Tests Given															
None															
60. Comments on History and Findings: AME shall comment on all "YES" answers in the Medical History section and for abnormal findings of the examination. (Attach all consultation reports, ECGs, X-rays, etc. to this report before mailing.)												FOR FAA USE			
28: Tonsillectomy None												Pathology Codes			
												Coded By			
												Clinical Reject			
Significant Medical History				<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		Abnormal Physical Findings				<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
61. Applicant's Name ANDREAS Guenter LUBITZ				62. Has Been Issued -- <input type="checkbox"/> Medical Certificate <input checked="" type="checkbox"/> Medical & Student Pilot Certificate <input type="checkbox"/> No Certificate Issued -- Deferred for Further Evaluation <input type="checkbox"/> FAA ATC-Deferred -- No Certificate Issued <input type="checkbox"/> Has Been Denied -- Letter of Denial Issued (Copy Attached)											
63. Disqualifying Defects (List by item number)															
64. Medical Examiner's Declaration -- I hereby certify that I have personally reviewed the medical history and personally examined the applicant named on this medical examination report. This report with any attachment embodies my findings completely and correctly.															
Date of Examination				Aviation Medical Examiner's Name				Aviation Medical Examiner's Signature							
MM DD YYYY				MATTHIAS J A VON MUELMANN											
04/09/2008				Street Address LH-BASE FRA PM/F				AME Serial Number 15851							
				City FRANKFURT AM State Zip Code 60546				AME Telephone 496969647601							

Form 8500-8 Continuation Sheet

Applicant Name : ANDREAS Guenter LUBITZ

Applicant MID : 200003801199

17.a. Medications (From page 1):

Medication

Previously Reported

Yes No

18. Explanations (From page 1):

19. Visits to Health Professional Within Last 3 Years. (From page 1):

Notes (From page 2):

28: Tonsillectomy

Other Tests Given (From page 2):

None

Comments on History and Findings (From page 2):

28: Tonsillectomy None

AME Actions:

Applicant Previously Assessed

☐ 1. Has OSA diagnosis and is on Special Issuance. Reports to follow.

☐ 2. Has OSA diagnosis and is currently being treated OR has had previous OSA assessment. NOT on Special Issuance. Reports to follow.

Applicant Not at Risk

☐ 3. Determined to NOT be at risk for OSA at this examination.

Applicant at Risk/Severity to be Assessed

☐ 4. Discuss OSA risk with airman and provide educational materials.

☐ 5. At risk for OSA. AASM sleep apnea assessment required. Reports to follow.

Applicant Risk/Severity high

☐ 6. ~~Deferral~~ Immediate safety risk. AASM sleep apnea assessment required. Reports to follow.